REPUBLIC OF GHANA

What works? What fails?

FINDINGS FROM THE NAVRONGO COMMUNITY HEALTH AND FAMILY PLANNING PROJECT

NAVRONGO HEALTH RESEARCH CENTRE

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FERTILE GROUNDS FOR FAMILY PLANNING

Fertility levels in Sahelian West Africa are double those observed in other developing countries. Many respected observers have emphasised the resilience of pronatalist social institutions in this region by noting that African religious customs, lineage and descent systems, kinship networks and family structure reinforce high fertility social norms, beliefs and values. The position supports the view that high fertility is a reflection of the desire for children, and that improving access to family planning services will have little or no effect on fertility. Other analysts who have assessed the implications of successful pilot family planning programmes have concluded that existing demand for services is sufficient to bring about a reduction in fertility.

Can family planning bear fruit among people who put a premium on large family size?

Despite a climate of uncertainty about what works in such settings, most reproductive health programmes in sub-Saharan Africa focus on improving access to family planning services. In the 1980s public investments in family planning focused on constructing sub-District clinics and posting large numbers of Community Health Nurses to them—resulting in far more nurses sitting in clinics than were needed to care for walk-in patients. This had the unintended effect of isolating public investments in health care from communities that the programmes are meant to serve. Even if programmes can be shown to bring about increases in contraceptive use, whether this increased use translates into fertility decline is yet to be demonstrated. Attention was also directed to deploying volunteers as "Community-based Distribution" (CBD) agents, without systematic investigation into how CBD should be organized and whether it actually works.

The Community Health and Family Planning Project (CHFP) set out to measure the relative impact of different types of health delivery strategies in a rural community. The experiment had a research design to provide a basis for understanding the process of reproductive change. Baseline characteristics of the population of women of reproductive age and their husbands were documented. Follow-up panel surveys and a longitudinal demographic surveillance system monitored changes in contraceptive knowledge, reproductive preferences, reproductive behaviour, and fertility. Four cells represented different health service delivery strategies. The Ministry of Health approach focused on fixed-facility health care delivery under which essential resources are lacking, community mobilization and supervising systems are weak, and community accountability is rarely developed.

Under the Nurse outreach arm, a Community Health Officer (CHO) is deployed to live among the people and provide doorstep and compound-specific health care. This approach bridges social distance between service provider and client, thus making the service delivery atmosphere friendlier. The *zurugelu* arm directed attention at using community-level cultural resources to organise health care delivery. This approach involves constituting health care action committees from existing social networks, and implementing supervisory services with active traditional village self-help schemes. The services are provided through the use of community health volunteers who are chosen by the community and trained by project staff to provide basic health care services, reproductive health education, outreach to men, and contraceptive supplies. Outreach to men is undertaken by community gatherings known as *durbars* at which discussions focus on health and family planning themes to give men an open forum to discuss their reactions to the programme. The gender strategies and communication activities of the *zurugelu* arm of the experiment were expected to alter the social context of reproductive change by legitimizing the concept of family planning among men, by opening community dialogue about health and reproductive matters that traditionally were not discussed between

spouses, and by involving women in social leadership that previously had been the preserve of men. The third arm of the experiment combines the MOH nurse outreach services and the *zurugelu* approaches. The hypothesis to be tested here was that the social costs of contraception can be reduced through community mobilization.

The context

The Kassena-Nankana district is located in the most impoverished region of Ghana. The study area is therefore remote and isolated although with limited exposure to outside influences and ideas arising mainly from trade and migration to southern Ghana. The hostile ecology and dispersed settlement pattern accentuate social isolation and complicate efforts to organise health and human services in the locality. Most of the populations are Kasem and Nankam speakers. These are ethnic groups with historic migratory links with Sahelian people to the north of Ghana. Local languages thus provide only fragmentary communication links to Ghana's southern cultures and restrict exposure of the population to outside ideas generally.

A good harvest doesn't depend on the number of crops grown and labour invested—the crucial issue is how the crops are spaced

The adoption of modern family planning methods is constrained by various cultural traditions that restrict women's autonomy and shape men's perceptions of the value of children. Baseline data show that 42 percent of all currently married women were in polygamous unions in 1993. Baseline literacy of currently married women is only 7 percent further isolating women from the outside world. Taken together, the institution of marriage and the extended family system impede the introduction of new ideas about contraceptive technology. Focus group discussions suggest that womens' decision to adopt contraception is often at odds with perceptions of appropriate female roles and the decision may cause contraceptive adopters considerable risk of embarrassment and ostracism from their husbands, co-wives, and kin. Despite these constraints on contraceptive use, knowledge of methods was widespread in the baseline period. The ability to spontaneously name a modern contraceptive method ranged between 32 and 52 percent of respondents in the various treatment cells in 1993. Although most women knew of a method when prompted and could identify a supply source for a modern method when asked, baseline prevalence of contraceptive use was low in all treatment areas especially in the comparison area of the experiment.

Women have expressed their fertility preference for spacing childbirth but we are still far from the end of the road

Despite social constraints to contraceptive use, more than one third of respondents in the 1993 baseline survey expressed fertility preferences for spacing additional births. Although traditional reproductive control mechanisms such as prolonged postpartum abstinence are widespread and may reduce fertility substantially, child spacing preferences stated in surveys are consistent with family planning. This suggests that desire for fertility control exists that could be addressed with services. Is the issue of "unmet need" an artifact of biases that are associated with the survey interview paradigm in this setting? Can demand stated in survey data be met with services? These issues have been thoroughly investigated and sizzling results are now being made available. Interested in finding out the outcome of investigations? Grab the upcoming note titled, "*Women Speak, Men Listen*".

Send questions or comments to: What works? What fails?
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